DETROIT MERCY DENTAL CLINIC

Patient Referral Form

2700 Martin Luther King Jr. Blvd.
Detroit, MI 48208-2576
313-494-6700

University Health Center, 4201 St. Antoine
Detroit, MI 48201
313-494-6700

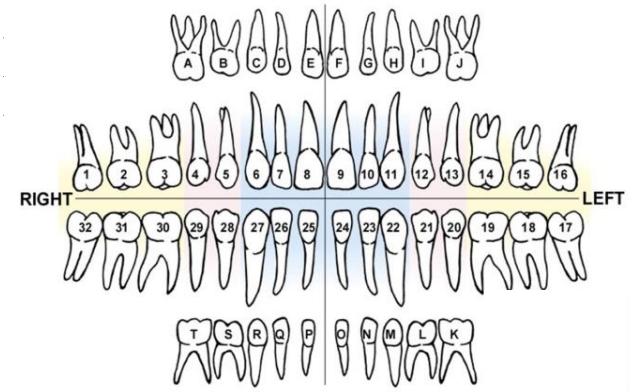
PATIENT INFORMATION

Last name:	First name:	Sex:
Phone: ( )	Date of Referral:	DOB:

DEPARTMENT FOR REFERRAL (PLEASE CHECK ALL THAT APPLY)

☐	Oral Surgery	(313)494-6648	☐ Periodontics	(313)494-6647
☐	Orthodontics	(313)494-6731	☐ Endodontics	(313)494-6729
☐	Diagnostic Imaging	(313)494-6718	☐ Advanced Education in General Dentistry AEGD	(313)494-6873
☐	Faculty Practice	(313)494-6730	☐ Pedodontics	(313)494-6701

REASON FOR REFERRAL



REFERRING DENTIST MUST PROVIDE THE FOLLOWING INFORMATION

Date of last exam: Date of last FMS: Date of last BW x-rays:

Patient returning to referring doctor for final restoration ☐ Yes ☐ No If no please provide details

Referred by: _____

Address: _____

City/Zip code: _____

Telephone number: ( ) _____

Signature of referring Dr. _____ NPI Number: _____